Request for State or Federal Workers' Compensation Information

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U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

The requested Information is needed to process a claim under the Black Lung Benefits Act (30 U.S.C. 901 at. seq.).

OMB No. 1215-0060
Expires: 10-31-04

I. IDENTIFICATION OF MINER (To be completed by DOL Claims Examiner)

TO:

a. Name of Miner (First, Middle, Last)

b. Name of Claimant (if different from miner)

2. Address (Number, street, city, state, Zip code)

city:
state: zip:

3. Employer's Name and Address

name:
line 1: city:
line 2: state: zip:

4. Miner's Social Security Number

5. State or Federal Claim Number(s)

6. Signature of DOL Claims Examiner

7. Date (Month, day, year)

II. **WORKERS' COMPENSATION INFORMATION** (To be completed by a State or Federal Workers' Compensation official)

Please complete all items as appropriate including Item 5 if no claim number is provided. Forward Copy-1 to the Division of Coal Mine Workers' Compensation and retain Copy-2 In your flies for use in notifying the DCMWC of any change In the miner's workers' compensation status or rate.

8. Has the miner or his widow filed a claim for workers' compensation benefits due to pneumoconiosis or other chronic lung disease?

☑ Yes ☐ No (If "Yes", complete items 9, 10 and 11, as appropriate.)

9. Status of Claim:

☐ Approved ☐ Denied ☐ Pending

10. Payment Information

a. Date began
b. Expiration date
c. Weekly Amount $
d. Lump sum amount $
representing settlement at $
per week for weeks beginning
e. Date of Lump sum payment
f. Are medical treatment expenses covered? ☑ Yes ☐ No

11. Were fees or Expenses paid out of the Award?

a. Attorney Fees ☐ Yes $ (Amount) ☐ No ☐ Unknown

b. Other extraordinary expenses (if "Yes", explain under "Remarks") ☐ Yes $ (Amount) ☐ No ☐ Unknown

12. Remarks:

Return To: U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

13. Signature and Title

14. Date (Month, day, year)

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Coal Mine Workers' Compensation, Room C3526, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

Copy I - Return to DCMWC Copy 2 -Retain for Status or Rate Change Notification Copy 3 - DCMWC File Copy

Form CM-905
Rev. Dec. 1999

Persons are not required to respond to this collection of information unless It displays a currently valid OMB control number.